How do we engage global communities in the de-stigmatisation of mental illness?

Paul Illingworth

ABSTRACT

The World Health Organization (WHO) has acknowledged that high-income countries often address discrimination against people with mental health problems, but that low/middle income countries often have significant gaps in their approach to this subject—in how they measure the problem, and in strategies, policies and programmes to prevent it. Localised actions have occurred. These include the Hong Kong government's 2017 international conference on overcoming the stigma of mental illness, has seen several developments as a result, the 2018 London Global Ministerial Mental Health Summit, and the UK's Medical Research Council has funded Professor Graham Thornicroft (an expert in mental health discrimination and stigma), to undertake a global study. These and other approaches are welcome and bring improvements; however, they often rely on traditional westernised, 'global north' views/approaches. Given rapid global demographic changes/dynamics and lack of evidence demonstrating progress towards positive mental health globally, it is time to consider alternative and transformative approaches that encompasses diverse cultures and societies and aligns to the United Nations' Sustainable Development Goals (SDGs), specifically UN SDG 3 (Good health and wellbeing). This article describes the need for the change and suggests how positive change can be achieved through transnational inclusive mental health de-stigmatising education.

Key words: Mental health ■ Transnational ■ De-stigmatising ■ Education

Some countries embrace, and others exclude, people with a mental illness. There are multiple contextual reasons why there is a need to develop alternative mental health de-stigmatising education. These include global/geographical, political, societal, cultural, religious and professional influences. The prevalence of mental health-related problems globally has been a concern for many years. The World Health Organization (WHO) acknowledged that, in high-income countries, this is often, though not always, being addressed and that low- and middle-income countries often have a 'significant gap' in how they 'measure the problem, and in strategies, policies and programmes to prevent mental disorders' (WHO, 2014:8).

Evidence exists that suggests there are factors that can delay or even prevent the treatment of mental illness (Corrigan, 2004; Henderson et al, 2013). These factors include poor understanding of mental illness as well as prejudice and discrimination against people with a mental illness. There have been several attempts to demonstrate how stigma has a major impact on whether health intervention is sought (for example by Link et al (2016) and Scott et al (2015). By inference, through changing these factors, it should reduce stigma towards those with a mental illness, but also help people to seek out and participate in mental health care.

There have been a number of attempts to address this. In 2017, the Hong Kong government held a 'Mental Health Matters: Overcoming the Stigma' conference, which the author attended, and which led to developments such as the establishment of the charity MIND HK. The international forum brought together national and international care providers, corporations, educators, government representatives, health and human resource professionals, public health specialists, media, non-government organisations (NGOs) and many more to generate practical solutions that could be actioned with the aim of making the subject less of a taboo.

Additionally, the first Global Ministerial Mental Health Summit, held in London in 2018, brought together experts and high-profile individuals to seek solutions as to how stigma relating to mental health disorders could be reduced. Additionally, the Medical Research Council (MRC) has funded a £2 million grant to Professor Sir Graham Thornicroft, a leading expert in mental health discrimination and stigma, to undertake a global study of the subject (MRC, 2018).

Furthermore, Stangl et al (2019) developed and proposed the Health Stigma and Discrimination Framework. Although not exclusively developed for mental health, the framework is interesting as it is a 'global, crosscutting framework based on theory, research, and practice'. The framework also attempts to move from a psychological model that focuses on 'stigma as a thing which individuals impose on others' and instead emphasises, 'the broader social, cultural, political and economic forces that structure stigma' (Stangl et al, 2019). Although this is an interesting development, and one worth exploring, it does still appear to follow a western and predominantly medical model.

Although these approaches, and others, are welcome and have begun to bring about some improvements, they all rely on high-income countries and the traditional westernised, 'global north' views and approaches. These approaches also often need the internet to disseminate what is being undertaken. Professor

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Thornicroft's study will specifically look at how low-income countries can be involved, which is something to be welcomed (Thornicroft, 2018). However, given rapidly changing global demographics and lack of evidence demonstrating progress towards positive mental health in many cultures and countries, a change in approach is needed.

An alternative approach

The author believes it is time to consider an alternative and transformative approach to reduce stigma relating to mental health disorders for ethnically, culturally and socially diverse people, including migrants and refugees. Many parts of the world do not have regular and consistent electricity supplies, let alone Wi-Fi or internet access. The author believes we should be exploring more sustainable means of developing and delivering transnational and inclusive mental health awareness education (TIMHDE). Therefore, any such development needs to be aligned to the United Nations' (UN) Sustainable Development Goals (SDGs) specifically UN SDG3 (good health and wellbeing). This states:

> **'Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states'.**
>
> ***UN, 2015***

It is encouraging that the UN SDG3 includes specific targets on mental health (*Table 1*), with mental illness being one of the greatest challenges globally. Despite there being numerous calls for mental health to be included in the development agenda for many years (Mills, 2018), it is interesting to note that the targets are, for the most part, directed at treating and to a lesser extent preventing mental illness. It only makes a passing statement on promoting mental health and wellbeing and makes no mention of working to reduce the stigma surrounding mental illness in societies.

This subject received further prominence from Dainius Puras (UN Special Rapporteur on health) in the UN General Assembly report (UN, 2019), who emphasised that addressing inequality and discrimination would have a greater positive effect on mental illness than medication and therapy, which has been the emphasis for the past 30 years. And a recent critical review of Patel et al's (2018) *Lancet* global mental health report by Cosgrove et al (2020), further emphasises the need to move away from what it calls the 'global north' driving the global south and not using local cultures to try bring improvements (Cosgrove et al, 2020), supporting further criticism by Jenkins (2019).

Additionally, the following SDGs will need addressing:

- SDG 4 (quality education)
- SDG 5 (gender equality)
- SDG 10 (reduce inequalities)
- SDG 16 (peace, justice and strong institutions)
- SDG 17 (partnerships for the goals).

The following SDGs also underpin TIMHDE:

- SDG 12 (responsible consumption and production)
- SDG 13 (climate action) (UN, 2015).

Table 1 UN Sustainable Development Goal 3 relating to mental health

SDG3: Ensure healthy lives and wellbeing for all at all ages	
Target 3.4	Countries should 'reduce by one third premature mortality from non-communicable disease through prevention and treatment and promote mental health and wellbeing by 2030' ■ Indicator 3.4.2: suicide mortality rate
Target 3.5	Countries should 'strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol' ■ Indicator 3.5.1: coverage of treatment interventions for substance use disorders ■ Indicator 3.5.2: harmful use of alcohol (per capita consumption)
Target 3.8	Countries should 'achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective quality and affordable essential medicines and vaccines for all' ■ Indicator 3.8.1: coverage of essential health care services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn, and child health, infectious disease, non-communicable diseases, and service capacity and access, among the general and most disadvantaged population) ■ Indicator 3.8.2 number of people covered by health insurance or a public health system per 1000 population

Mental health: global perceptions

Mental health disorders are often perceived differently in different countries and in many communities within countries, including immigrant communities. Some embrace and include those with mental ill health, while others actively segregate and discriminate. Some cultures do not have words to describe the conditions that western medicine uses, such as depression. As Antonovsky (1979) argued, the meanings people give to their lived experience when in distressing situations can give them a sense of coherence, which then impacts on their ability to cope. Rabaia et al (2014) also suggested that, what is tacit knowledge about mental health in some cultures has no meaning in others. If health professionals use terminology alien to a culture, this will create communication problems. This means that championing and using standardised approaches will risks overlooking or disbelieving different ways of understanding mental illness in a different dialect or culture. This is something Patel et al (2018) have been criticised for doing.

One example of a communication problem occurred to the author many years ago, when working as a mental health nurse in the UK. The author was caring for a man who had migrated to the UK from Pakistan and who had good command of English. However, he was unable to describe how he was feeling other than to say his 'heart was falling'. It would have been easy for the author to report that the patient was suffering derealisation or depersonalisation, both symptoms of what can be called a disassociative disorder (NHS website, 2020) but that was not what he meant. It was not until his family visited and his daughter explained they did not have a word for depression in their culture, that the author then understood what he was trying to describe.

Many examples of segregation and discrimination have been

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documented. In some sub-Sahara African countries people with a mental illness have had their basic human rights denied, with accounts of people being chained up (Fleischer, 2014; Bukuwa, 2019), although Bukuwa (2019) also reported on new laws introduced in Uganda to protect the rights of people with a mental illness. Additionally, Yates (2018) reported mental illness is heavily stigmatised in the Middle East and North Africa.

Discrimination and segregation have also been reported in Asia. Mahomed et al (2019) undertook research in Gujarat, India, exploring the role, positive and negative, the family plays when a family member has a mental illness. The research showed that families were crucial in providing support but that a majority of those involved in the qualitative study (14 from 17 participants) experienced stigma from their family in the form of lack of knowledge, prejudicial attitudes and discriminatory behaviours. Additionally, they found gender differences in experiences, but this is not just in relation to mental health, with examples of menstrual stigma even leading to the deaths of some women (Parker and Standing 2019). This familial discriminatio n was further exemplified in a Nepal newspaper article, which described Ketan Dulals's own treatment by his family from when he began experiencing psychotic episodes (Dulal, 2017).

This stigmatisation in low- and middle-income countries will be one of the key influences on the development of TIMHDE. Not only would terminology be a key determinant but it is also important to understand how political and religious influences impact on associated stigma. In addition, it is important to understand how education can be provided, from both a physical perspective (delivery mode/modes) and communication (language/imagery) and a human resource perspective. Additionally, the materials will need to be sustainable and address the UN SDGs highlighted above. By encompassing global perspectives from low- and middle-income countries, TIMHDE would avoid a global north determination of what and how it is delivered.

As can be seen, there are several significant influences which could guide the development of TIMHDE. These include: moves to destigmatise mental illness, certainly in some western countries, together with the attention being given to the subject through the recent ministerial global mental health summit and MRC-funded research of Professor Thornicroft. All these moves indicate that it is timely to explore the perceptions, motivations and socialisation of various societies towards mental ill health and associated stigma.

What is meant by TIMHDE?

For TIMHDE to work, there are fundamental principles that must be set out to fortify the development and eventual role out. There needs to be global involvement in the development. A white, western, medical model should not be the driving force; we have been trying that for many years without significant improvement (UN, 2019). There needs to be a pulling together of what has worked around the world and then these approaches should be adapted and applied with a localised perspective. For example, in the UK, high profile celebrities such as Stephen Fry, and a current English footballer, Danny Rose, have openly discussed their mental ill health. Additionally, members of the British royal family, Prince William and Prince Harry have both described their own experiences in coming to terms with their mother, Princess Diana's, tragic death and the emotional challenges they faced in their time in the armed forces. This willingness to openly admit to having mental health problems and the lived experience of mental illness, is seen by others as giving permission to admit they too suffer mental ill health. This openness was again highlighted at the World Economic Forum's Annual Meeting in Davos in January 2019, where the importance of mental health was emphasised by Prince William, Dixon Chibanda, founder of the Friendship Bench and United for Global Health Ambassador, and world leaders such as New Zealand Prime Minister Jacinda Ardem.

But such approaches will not work everywhere and we need to do more. Several parts of the world do not follow a celebrity culture. There are numerous examples to show that people with a mental illness are often still treated as something less than second-class citizens. Hammond (2013) drew mentally ill people being shackled and neglected in South Sudan and other Sub-Sahara African countries to the world's attention, but there are many other examples of neglect and abuse. Yet there is hope, Chibanda and London (2019) described the Speak Your Mind campaign, which involves 15 countries and is a global civil society movement to get health ministers to invest in education and empower societies to end stigma.

The different perceptions, in many countries, towards people with a mental illness, would need to be one of the key influences on how TIMHDE is developed. To achieve this transnational approach, people from all continents, representing low-, middle- and high-income countries, and most importantly, those with lived experience, would need to collaborate on an equal basis. To ensure consistency, learning aims and outcomes would need developing and agreeing before developing the content to be presented. Further, the subject matter would need to be developed in such a way as to enable delivery to be adaptable to the country, society and culture within which it was to be delivered; in other words, produced in such a way that they could be transnationally designed for learning.

Conclusion and recommendations

Without doubt, mental health stigma is one of the biggest challenges globally. The international climate is now ready to change and we must all embrace this to improve mental health for all by reducing stigma.

The author calls upon everyone working in the field of mental health to work towards:

- Developing a global collaborative de-stigmatising network
- Clarifying what has/is working globally to reduce mental health stigma
- Agree transnational global education aims and learning outcomes
- Develop localised teaching materials to achieve the aims and outcomes in a format appropriate to that country, society and culture
- Develop 'train the trainer' materials
- Oversee the delivery
- Evaluate the impact.

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Developing a transnational collaborative approach will enable current best practice to be applied globally but, at the same time, applying it in a culturally sensitive way. Ultimately, this will lead to reduced stigma toward mental illness in societies, resulting in people seeking earlier interventions for their mental health problems. **BJN**

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KEY POINTS

- There is a need to understand why prejudice and discrimination against people with a mental illness still exists
- Reluctance to acknowledge mental health issues can be due to several factors including global/geographical, political, societal, cultural, religious and professional
- Anyone working with people with mental health problems and who are from a different culture/background to themselves should attempt to understand how the above factors may affect their chance of success
- Alternative ways of working with people from different cultures should play an important part in their care and not just a white, western, medical model

CPD reflective questions

- Think about why there is a need to develop alternative mental health de-stigmatising education
- Consider why Transnational Inclusive Mental Health De-Stigmatising Education (TIMHDE) could achieve positive change
- Think about how TIMHME could help you approach mental health issues with people you are caring for, who come from a non-westernised culture

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